



**WELCOME BACK
TO THE
PROFESSIONAL EYE CARE CENTER!**

Thank you for allowing us to continue serving your eye care needs. Please help us to keep your file current by completing the following:

Today's Date:

Name
(Last) _____ (First) _____ (Middle) _____

- I have reviewed my address, phone number and employment information that is currently on file with the front desk staff and nothing has changed**

Please indicate changes/updates:

Address _____
City/State/Zip _____

Telephone (Home) _____ (Work) _____
Employer _____ Occupation _____

Please update your medical history:

1. Are you currently under a physician's care?..... oYes oNo
If yes, for what conditions? _____ Dr.'s name _____
2. Are you currently taking any medications?.....oYes oNo
If yes, please list: _____
3. Do you have:(circle all that apply) **Diabetes High Blood Pressure Fibromyalgia
High Cholesterol Cancer Rheumatoid Arthritis**
4. Are you interested in learning more about laser vision correction? oYes oNo

Office Policy

It is customary to pay for all services as they are rendered.

Please be prepared to pay all co-payments today with cash, check or charge. There is a \$25 billing fee if you exam co-payment is not paid today.

Professional fees are non-refundable. Spectacles and contact lenses are considered custom orders that have been prescribed by the doctor and are not transferable from one individual to another. Professional Eye Care Center will extend refunds and credits for these items based on manufacturers' warranties/credit policies and are subject to restocking fees.

Delinquent accounts are subject to a monthly service fee. There is a \$35 service charge on all returned checks.

Signature _____ Date _____